GENERAL GUIDELINES

1. All schemas apply to all histologies unless otherwise noted. Derived data fields SS1977 and SS2000 are generated for all sites and histologies. The TCR does not collect all the data items necessary to derive the TNM stage.

2. ***Timing of Data Collection:*** The data collected in the CS System are limited to:
   a. Information gathered through completion of surgery(ies) in first course of treatment, OR
   b. All information available within four months of the date of diagnosis in the absence of disease progression, (metastasis known to have developed after the diagnosis and initial staging was established should be excluded); *whichever is longer.*

3. **Site-specific** and **histology-specific** guidelines take precedence over general guidelines. Always read the notes pertaining to a specific site or histology schema.

4. For each field, code the highest applicable number. The codes are ordered in a hierarchy so that increasing numbers generally indicate increasing degrees of tumor involvement. The hierarchies are not the same for the different staging systems and CS generally follows the hierarchies of the TNM system.

EXCEPTION: *Codes for Unknown, Not Applicable, and NOS categories (Such as Localized, NOS) do not take priority over more specific codes with lower numbers.*

EXCEPTION: *Combination codes (such as code 35 for "25 plus 30") have been assigned when using the higher number does not result in the appropriate mapping for all three of the stage groups. Combination codes have been omitted when use of a higher number results in correct mapping for all three of the staging systems.*

5. For the fields CS Tumor Size, CS Extension, CS Lymph Nodes, and CS Mets at DX, CS records the greatest extent of disease based on combined clinical and operative/pathological assessment.

Note: *Gross observations at surgery are particularly important when all malignant tissue is not removed.*

Note: *In the event of a discrepancy between pathology and operative reports concerning* ***excised*** *tissue, priority is given to the pathology report.*

Note: *Clinical information should be reviewed carefully to assure accurate recording of CS data sets. Information such as description of skin involvement for breast cancer, and size of the primary lesion and distant lymph nodes for any site, can change the stage.*

6. When the patient does not receive preoperative treatment and the operative/pathology information disproves the clinical information, code the operative/pathology information.

7. When the patient does not receive preoperative treatment, the greatest extent of disease should be recorded whether that is determined clinically or postoperatively.

Note: *Preoperative treatment is defined as systemic (chemotherapy, hormone therapy, or immunotherapy) treatment or radiation therapy that is administered as an attempt to shrink the tumor, improve the outcome of resection of tumor, or control symptoms before the patient has surgery.*

8. When the patient does receive preoperative treatment, the greatest extent of disease prior to the beginning of treatment should be recorded. In the infrequent situation where post-operative disease (CS Extension) is more extensive despite neoadjuvant treatment, this can be coded in the method of evaluation field for extension (CS Size/Ext Eval).

9. The fields Reg LN Pos and Reg LN Exam are based on pathologic (microscopic) information only.

Note: *These are not new data fields. The TCR has collected these data fields since 1998. These two data fields are part of the CS System and have been incorporated into this section and added to the standard table of the 2008 TCR CRH.*

10. **The TCR will only collect the Site Specific Factor's (SSF) for sites required to derive the SS.** SSF 1 will be collected for pleura primaries (C38.4) and SSF 3 for prostate primaries (C61.9). Information on pleural effusions is collected in SSF 1 in the pleura schema and pathologic information from prostatectomy is collected in SSF 3 in the prostate schema.

11. Metastasis known to have developed after the initial extent of disease was established (disease progression) should be excluded when determining the farthest extent of disease at the time of diagnosis.

12. Autopsy reports are used in coding the CS System in the same way as pathology reports, applying the same rules for inclusion, exclusion, and extent of disease.

13. The TNM characteristics do not always translate one to one for SSS and does not meet the documentation requirement. TNM values should not be documented as staging information. The TCR **does not accept** TNM staging to code or evaluate the accuracy of CS coding. The only exception to this is when the T, N, or M values are under the Description Column in the schema, such as code 18 under the CS Lymph Nodes on page A-109.

CHOOSING THE CORRECT CODING SCHEMA FOR A CASE

Most of the Collaborative Staging System schemas apply to cases defined by their primary site codes in ICD-O-3. A few of the schemas apply to cases defined by their **histologic type codes** in ICD-O-3, and **these schemas take precedence over the schema for the primary site**. The histologically defined schemas are:

- Melanoma (ICD-O-3 morphology codes 8720-8790)
- Kaposi Sarcoma (9140)
- Retinoblastoma (9410-9514
- Lymphoma (9590-9699 and 9702-9729)
- Mycosis Fungoides (9700-9701)
- Hematopoietic and reticuloendothelial system (9731-9989)

A case with one of these ICD-O-3 histologic types must be coded using the schema for the histologic type group. Each schema clearly states the applicable primary site codes and histologic type codes at the beginning of the schema.

Melanomas are further broken down by primary site code as follows:

- Malignant melanoma of skin, vulva, penis and scrotum (C440-C449, C510-C512, C518-C519, C600-C601, C608-C609, C632)
- Malignant melanoma of conjunctiva (C690)
- Malignant melanoma of iris and ciliary body (C694)
- Malignant melanoma of choroid (C693)
- Malignant melanoma of other eye (C691, C692, C695, C698-C699)

Note**: The appropriate site or histology schema to use for coding surgical treatment(s) may be different from the site or histology schema used for coding the Collaborative Staging data set.* ***For example, an extralymphatic lymphoma of the stomach (C16) treated surgically would use the lymphoma schema to code CS, but surgery would be coded using the surgery codes for stomach (C16). Refer to pages 110-112 of the Treatment Section for further information. *Lymphomas are coded to the site and staged to the disease.*

ADJACENT CONNECTIVE TISSUE

Some of the CS System schemas for ill-defined or non-specific sites in this manual contain a code for adjacent connective tissue, which is defined here as the unnamed tissues that immediately surround an organ or structure containing a primary cancer.

ADJACENT ORGANS

Organs are anatomic structures with specific physiologic functions other than (or in addition to) support and storage.

ADJACENT STRUCTURES

Connective tissues large enough to be given a specific name would be considered adjacent structures.

AMBIGUOUS TERMINOLOGY

Determination of the cancer stage is both a subjective and objective assessment of how far the cancer has spread. Refer to the following table for the list of ambiguous terms to be used for CS only.

Consider as Involvement

adherent	induration
apparent(ly)	infringe/infringing
appears to	into*
comparable with	intrude
compatible with	invasion to, into, onto, out onto
consistent with	most likely
contiguous/continuous with	onto*
encroaching upon*	overstep
extension to, into, onto, out onto	presumed
features of	probable
fixation to another structure**	protruding into (unless encapsulated)
fixed**	suspected
impending perforation of	suspicious
impinging upon	to*
impose/imposing on	up to
incipient invasion	

***interpreted as involvement whether the description is clinical or operative/pathological**

****interpreted as involvement of other organ or tissue**

Note: Do not use this list for determining reportability of a case or for determining Primary Site or Histology.

Do Not Consider as Involvement

abuts	extension to without invasion/involvement of
approaching	kiss/kissing
approximate	matted (except for lymph nodes)
attached	possible
cannot be excluded/ruled out	questionable
efface/effacing/effacement	reaching
encased/encasing	rule out
encompass(ed)	suggests
entrapped	very close to
equivocal	worrisome

NOTE: Do not use this list for determining reportability of a case or for determining Primary Site or Histology.

CODING "NONE" VS. "UNKNOWN" IN THE COLLABORATIVE STAGING SYSTEM

As noted in the introduction, cancers of certain primary sites are not easily examined by palpation, observation, physical examination, or other clinical methods. These "inaccessible" primary sites include (but are not limited to) bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri and ovary.

A coding rule in the Collaborative Staging System applies to these inaccessible sites, **primarily for localized or early stage** cancers. The Collaborative Staging System allows data collectors to record regional lymph nodes as negative (based on clinical evaluation) rather than unknown when there is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing, or surgical exploration, and the patient receives what would be usual treatment to the primary site (treatment appropriate to the stage of disease as determined by the physician).

This new coding guideline also permits data collectors to record distant metastasis clinically as none rather than unknown (again, based on clinical evaluation) for inaccessible site when the clinician proceeds with usual treatment of the primary site, since this action presumes that there are no distant metastases that would otherwise change the treatment approach.

The code(s) for **unknown information can** and **should be used** in situations where there is reasonable suspicion that the tumor is **no longer localized**. For example, when there is clinical evidence that a prostate cancer has penetrated through the capsule into the surrounding tissues (regional direct extension) and regional lymph node involvement is not mentioned, it would be correct

to **code lymph node involvement and metastasis at diagnosis as unknown** in the absence of specific information regarding nodes or distant metastasis.

For accessible primary sites that can be observed, palpated or examined without instruments, including (but not limited to) breast, oral cavity, skin, salivary gland, thyroid, and other organs, there should be some description of the regional lymph node status. A statement such as "remainder of examination negative" is sufficient to code regional lymph nodes as clinically negative.

HOW TO CODE THE COLLABORATIVE STAGING SYSTEM DATA ELEMENTS

1. Before you begin to code using the CS System, read completely the general rules in Appendix A.

2. Read the medical record carefully to determine the primary site and histology and identify the correct ICD-O-3 codes. While you are reviewing the record, make mental notes about the tissues and lymph nodes that are involved by tumor.

3. If the histology is melanoma (8720-8790), Kaposi sarcoma (9140), retinoblastoma (9510-9514) lymphoma (9590-9699 and 9702-9729), mycosis fungoides (9700-9701), or hematopoietic and reticuloendothelial system (9731-9989), use the histology-specific schema for the appropriate histology-site combination.

4. Otherwise, turn to the correct site-specific schema in Appendix A. Schemas are in ICD-O-3 order by the first code that uses the schema. Verify that you are in the correct chapter by confirming that the code is in the list at the beginning of the schema.

5. Begin assigning codes for the 9 fields in CS that the TCR collects. Be sure to read the notes and follow the site/histology-specific instructions at the beginning of each data field. Keep in mind that Site Specific Factors are coded for Prostate and Pleura only.

   a. Code the tumor size in the CS Tumor Size field.

   b. Code how far the tumor has directly spread in the CS Extension field.

   c. Code how the farthest tumor spread/size was determined in the CS Tumor Size/Ext Eval field

   d. Code whether regional node spread was determined in the CS Reg Node Field.

   e. Code the number of histologically positive regional lymph nodes from the pathology report in the Reg Nodes Pos field.

   f. Code the number of regional lymph nodes examined by the pathologist in the Reg Nodes Exam field.

   g. Code the farthest distant metastases (including distant lymph nodes) in the CS Mets at Dx field.

   i. Code the presence or absence of pleural effusion in CS Site Specific Factor 1 for Pleura

primaries (C38.4). Code the furthest pathologic extension based on prostatectomy in CS Site Specific Factor 3 for Prostate primaries (C61.9)

You have now collected all the facts about the case needed to derive Summary Stage 1977 and Summary Stage 2000. The computer algorithm will also record which version of the Collaborative Staging System was used to derive the final stages. The correct algorithm must be used as edits will kick out older versions

CS TUMOR SIZE (NAACCR Item # 2800) (CS MANUAL Version 01.04.00 pg. I-25)

Description
Records the largest dimension or diameter of the ***primary tumor***, and is always recorded in millimeters.

Note: *To convert centimeters to millimeters, multiply the dimension by 10. If tumor size is given in tenths of millimeters, record size as 001 if largest dimension or diameter of tumor is between 0.1 and 0.9 mm.*

Tumor Size General Guidelines

Site/histology specific instructions replace or over-ride general instructions. In the absence of site/histology-specific instructions, general instructions apply.

1. Code and document tumor size information in the following order:

   a. Document tumor size from the pathology report, if available, when the patient receives no radiation or systemic therapy prior to surgery.

Example:
Chest x-ray shows 3.5 cm mass; pathology report from the surgery states the same mass is malignant and measures 2.8 cm. Tumor size should be documented as 2.8 cm and coded as 028.

   b. If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy or immunotherapy) or radiation therapy, document the largest size of tumor prior to treatment unless post-operative disease is more extensive.

Example:
Patient has a 2.2 cm mass in the oropharynx identified per CT; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives course of neoadjuvant combination chemotherapy. Pathologic size of tumor after total resection is 0.8 cm. Tumor size should be documented and coded as the pre-treatment size shown on CT, 022.

   c. Information on size from imaging/radiographic techniques can be used to code size when there is more specific size information from a pathology or operative report, but should be taken as low priority, just above a physical exam.

d. If there is a difference in reported tumor size among imaging and radiographic techniques, record the largest size of tumor reported in the record.

e. In the infrequent event that the tumor does not respond to neoadjuvant treatment and is, in fact, more extensive after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code CS Tumor Size/Ext Eval as 6, based on pathology/operative report after treatment and code the farthest extension/size.

Example:
Patient has a 3.5 cm mass in the left upper lobe per CT. Squamous cell carcinoma is identified by fine needle aspiration. Patient receives XRT to shrink the tumor prior to surgery. Pathological size of tumor after total resection is 4cm. The tumor size should be documented as 4cm and coded as 040.

2. Record the exact size of the primary tumor for all sites/histologies except those for which it is stated to not be applicable. If no size is given, code 999.

a. Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis. However, if the tumor is described as a "cystic mass", and only the size of the entire mass is given, code the size of the entire mass since the cysts are part of the tumor.

b. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

Example:
Tumor is describes as 2.4 x 4.1 x 1.8 cm in size. Tumor should be documented as 4.1 cm and coded as 041.

c. Record the size of the invasive component if given.

d. If both an in situ and an invasive component are present and the invasive component is measured, record the size of the invasive component even if it is smaller.

Example:
A 3.7 cm tumor is mixed in situ and invasive. The invasive component is 1.4 cm. Document invasive tumor size 1.4 cm and code size as 014.

e. Additional rule for breast primaries: if the size of the invasive component is not given, record size of the entire tumor from the surgical report, radiology report or clinical examination.

Example:
Infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Tumor size should be documented as 2.3 cm and coded as 023.

f. For purely in situ lesions, code the size as stated.

g. Microscopic residual tumor does not affect overall tumor size.

h. Do not add pieces or chips together to create a whole; they may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size.

i. If an excisional biopsy is performed and residual tumor at time of resection of the primary is found to be larger than the excisional biopsy, code the size of the residual tumor.

j. For an incisional biopsy, code the tumor size as 999 in the absence of a clinical size. Do not code the tumor size from a needle biopsy unless no residual tumor is found on further resection.

k. Record tumor size (lateral dimension) for malignant melanoma. Depth of invasion is coded in a Site Specific Factor which is not currently collected by TCR.

3. **Special Codes:**

a. Tumor dimension is to be recorded for all schemas, except as noted below. Other information collected in this field in previous staging systems, such as depth of invasion for melanomas, has been moved to SSF's for those sites/histologies. The TCR does not collect SSF's except for SSF 1 for pleura primaries (C38.4) and SSF 3 for prostate primaries (C61.9).

b. If size is not reported, code as 999, which means unknown size, not applicable, or not documented in the patient record

c. The descriptions in code 998 take precedence over any mention of size. Code 998 is used only for the following sites with the site specific descriptions.

Esophagus (C150-C155, C158-C159): Entire circumference
Stomach C160-C166, C168-C169): Diffuse, widespread-3/4 or more, linitis plastica
Colorectal (M8220-8221, with /2 or /3): Familial/multiple polyposis
Lung and main stem bronchus (C340-C343, C348-C340): Diffuse, entire lobe or lung
Breast (C500-C506, C508-C509): Diffuse

d. Code 990, microscopic focus or foci only; no size is given, should be used when no gross tumor is seen and tumor is only identified microscopically.

Note: *The terms microscopic focus, microfocus, and microinvasion are NOT the same as [macroscopic] focal or focus. A macroscopic focus or foci indicates a very small or isolated area, pinpoint, or spot of tumor that can be seen grossly.*

Examples:

1. Ovary specimen: extensive cystic disease with focal areas of tumor seeding. "Focal" should be disregarded and tumor size should be coded to 999.

2. Cervix conization: severe dysplasia with focal areas of microinvasion. Code tumor size to 990,

microscopic focus, no size given.

e. Codes 991 through 995 are non-specific size descriptions. If a more specific size is given, the more precise size should be coded in the range 001-989.

f. Other special codes in the range 996 to 997 are used on a site-specific basis. See the individual site/histology schemas for further information and definitions.

g. For the following diagnoses and/or primary sites, size is not applicable. Record as code 888.

Disseminated Langerhans cell histiocytosis (Letterer-Siwe disease)
Hematopoietic neoplasms
Immunoproliferative diseases
Leukemia
Malignant lymphoma (Hodgkin lymphoma and non-Hodgkin lymphoma)
Mast cell tumors
Multiple Myeloma and other plasma cell tumors
Myelodysplastic syndromes
Myeloproliferative diseases

4. Documentation of the tumor size and source of size is required in the Staging Documentation text field.

CS Tumor Size Standard Table

Note: *The table is also available in the Quick Reference, Standard Tables Section.*

Code	Description
000	Indicates no mass or no tumor found.
001-988	Exact size in millimeters.
989	989 millimeters or larger.
990	Microscopic focus or foci only; no size of focus is given.
991	Described as "less than 1 cm"
992	Described as "less than 2 cm," or "greater than 1 cm," or "between 1 cm and 2 cm"
993	Described as "less than 3 cm", or "greater than 2 cm," or "between 2 cm and 3 cm"
994	Described as "less than 4 cm," or "greater than 3 cm," or "between 3 cm and 4 cm"
995	Described as "less than 5 cm," or "greater than 4 cm," or "between 4 cm and 5 cm"
	SITE-SPECIFIC SCHEMA CODES WHERE NEEDED
999	Unknown; size not stated; not stated in patient record; Unknown primary

For schemas that do not use tumor size:

Code	Description
888	Not applicable

Examples:
a. Tumor of stated primary not found: ***Code as 000***

b. Mammogram shows 2.5 cm breast malignancy: ***Code as 025*** *(2.5 cm =2 5mm)*

c. CT of chest shows 4 cm mass in RUL: ***Code as 040*** *(4 cm = 40 mm)*

d. Thyroidectomy specimen shows 8 mm carcinoma: ***Code as 008***

e. Prostate needle biopsy shows 0.6 mm carcinoma: ***Code as 001*** *(round up six-tenths of mm)*

f. Tumor stated to be "less than 3 cm" with no further specific tumor size: ***Code as 993***

Size conversions for centimeters, millimeters, inches:
10 millimeters (mm) = 1 centimeter (cm)
1 millimeter (mm) = 1/10 centimeter (cm)
2.5 centimeters (cm) = 1 inch (in)
1 centimeter (cm) = .394 inch (in)

Note: *Documentation is required to support coding. Document the exact tumor size from the pathology report, imaging or physical exam. Specify if the patient had preoperative chemotherapy or radiation. Treatment includes surgery, chemotherapy, or radiation.*

DETERMINING DESCRIPTIVE TUMOR SIZE (NAACCR Item #780) (CS MANUAL Version 01.04.00 pg. I-66)

Descriptive Term	Millimeter Equivalent	Descriptive Term	Millimeter Equivalent	Descriptive Term	Millimeter Equivalent
EGGS		**MISCELLANEOUS FOODS**		**NUTS**	
Bantam	040	Doughnut	090	Almond	030
Goose	070	Lentil	991	Chestnut	040
Egg	050	Millet	991	Chestnut, horse	040
Hen	030	**MISCELLANEOUS ITEMS**		Hazel	020
Pigeon	030	Ball, golf	040	Hickory	030
FRUITS		Ball, tennis	060	Pecan	030
Apple	070	Baseball	070	Walnut	030
Apricot	040	Eraser on pencil	009	**OTHER TERMS**	
Cherry	020	Fist	090	Microscopic focus	990
Date	040	Marble	010	Size < 1 cm	991
Fig (dried)	040	Match head	009	Size between 1 and 2 cm	992
Grape	020	**MONEY**		**VEGETABLES**	
Grapefruit	100	Dime	010	Bean	010
Kumquat	050	Dollar, half	030	Bean, lima	020
Lemon	080	Dollar, silver	040	Pea	991
Olive	020	Nickel	020	Pea, split	991
Orange	090	Quarter	020		
Peach	060	Penny	010		
Pear	090				
Plum	030				
Tangerine	060				

CS EXTENSION (NAACCR Item # 2810) (CS MANUAL Version 01.04.00 pg. I-28)

Description
Identifies contiguous growth (extension) of the primary tumor within the organ or its direct extension into neighboring organs.

Note: *For certain sites such as ovary and corpus uteri, discontinuous metastasis is coded in the CS Extension field. Refer to site-specific schemas for detailed codes and coding instructions.*

CS EXTENSION GENERAL GUIDELINES

1. Code and document the farthest extension of the primary tumor. Do not code discontinuous metastases to distant sites in this data field.

2. Extension should be coded in the following order:

   a. Extension from the pathology report, if available, when the patient receives no radiation or systemic treatment prior to surgery.

   b. If the patient receives preoperative systemic or radiation therapy, code the farthest extension identified (clinically) prior to treatment.

Example:
Patient has rectal mass firmly attached to pelvic wall (CS Ext code 60). Patient undergoes preoperative radiation therapy. The pathology report from the low anterior resection shows residual tumor outside the rectum in perimuscular tissue (CS ext code 40). Code CS Ext 60, because the preoperative radiation therapy apparently "shrank" the tumor away from the pelvic wall.

   c. Farthest extension based on the pathology/operative report after treatment, in the event that the tumor does not respond to neoadjuvant treatment and is, in fact, more extensive after the preoperative treatment as determined by the operative or pathology report.

Example:
Patient found to have an obstructing central lung tumor very close to the main stem bronchus (CS Ext code 20). Patient undergoes six weeks of intensive chemotherapy. At thoracotomy, tumor was observed directly extending into trachea (CS Ext code 70). The tumor was noted to be more extensive after preoperative treatment and should be coded to 70.

   d. Extension from imaging/radiographic techniques can be used to code extension when there is not more specific extension information from a pathology or operative report, but it should be taken as low priority, just above a physical exam.

   e. If an involved organ or tissue is not mentioned in the schema, approximate the location in the same anatomic area and code accordingly.

   f. With the exception of corpus uteri, ovary, and prostate, extension codes represent direct

extension from the site of origin to the organ/structure/tissue.

Example:
Infiltrating ductal carcinoma of the right breast with extension to the chest wall would be coded in the CS Extension Data Field

3. Distant metastases must be coded in the CS Mets at DX data field.

4. Extension cannot be in situ if there is evidence of nodal or metastatic involvement. The CS Extension data field should be coded Localized, NOS if is no better information is available. Code CS Lymph Nodes and CS Mets at Dx appropriately.

Example:
Excisional biopsy of breast tumor shows extensive DCIS. Sentinel node biopsy reveals 3mm mets to one axillary node. Code CS Extension as localized, NOS, because an in situ tumor cannot metastasize and apparently an area of invasion was missed by the pathologist or not included in the specimen. Code CS Lymph Nodes to 25.

5. The presence of microscopic residual disease or positive margins does not increase the extension.

6. Extension and source documentation is required in the Staging Documentation text field.

Note: *Code 00 is* ***not*** *used for "none" or "no evidence of primary tumor". Code 00 indicates the tumor is in situ.*

CS Extension Standard Table

Note: *The table is also available in the Quick Reference, Standard Tables Section.*

Code	Description	TNM	SS 77	SS 2000
00	In situ; non-invasive	Tis	IS	IS
	SITE/HISTOLOGY SPECIFIC SCHEMA CODES			
80	Further contiguous extension			
95	No evidence of primary tumor	T0	U	U
99	Unknown extension; primary tumor cannot be assessed; not stated in medical record	TX	U	U

Note: *Documentation is* ***required*** *to support coding. Document extent of tumor involvement or extent of disease from pathology, surgery, or imaging reports and code the appropriate CS data fields. Be sure to state if information is pre or post treatment.*

CS TUMOR SIZE/EXT EVAL (NAACCR Item #2820) (CS MANUAL Version 01.04.00 pg I-30)

Description
Identifies how codes for CS Tumor size and CS Extension were determined based on the diagnostic methods employed.

CS Tumor Size/Ext Eval General Guidelines

1. Code and document the CS Tumor Size/Ext Eval code that documents the report or procedure from which the information about the farthest extension and/or size of the primary tumor was obtained; this may not be the numerically highest Eval code.

Example:
Fine needle aspiration biopsy (Eval code 1) confirms adenocarcinoma of prostate. CT scan of pelvis (Eval code 0) shows tumor extension through the prostatic capsule into adjacent connective tissues. Code CS Tumor Size/Ext Eval as 0 because the CT scan showed more extensive tumor than the biopsy.

2. For the certain sites/histologies tumor size is not a factor in determining the T category in TNM for ACoS facilities. For these sites code CS Tumor Size/Ext Eval on the basis of the CS extension field only. These sites are also noted in the site specific and histology specific schemas.

Note: *Although TNM staging is not collected by TCR, TNM is incorporated in the CS system; therefore rules must be consistent.*

Pharynx
Nasopharyx
Larynx
Glottic Larynx
Supraglottic Larynx
Subglottic Larynx
Nasal Cavity and Paranasal Sinuses
Nasal Cavity
Maxillary Sinus
Ethmoid Sinus
Esophagus
Stomach
Small Intestine
Colon and Rectum
Gallbladder
Extrahepatic bile ducts
Extrahepatic Bile Ducts
Other Biliary and Biliary, NOS
Ampulla of Vater
Pleural mesothelioma
Melanoma of Skin, Vulva, Penis, Scrotum
Vagina
Corpus Uteri
Ovary
Fallopian Tube
Gestational Trophoblastic Tumor
Placenta
Penis
Prostate
Testis
Renal Pelvis and Ureter
Urinary Bladder
Urethra
Malignant Melanoma of the Uvea
Iris and Ciliary Body-Melanoma
Retinoblastoma
Lymphoid Neoplasms
Mycosis Fungoides
Malignant Lymphoma

3. For primary sites where both tumor size and extension determine the T category in TNM select the code that best explains how the information in the CS Tumor Size and CS Extension fields were determined.

   a. If there is a difference between the derived category for the tumor size and the CS extension, select the evaluation code that reflects how the worse or higher category was determined.

   b. If the patient had no surgery, use code 0, 1, or 9.

Example:

A. Patient has a chest x-ray showing an isolated 4cm tumor in the right upper lobe. Patient opts for radiation therapy. Code this field as 0. Staging algorithm would identify information as clinical (c).

B. Colon cancer with colonoscopy and biopsy confirming cancer. Code this field as 1. Staging algorithm would identify information as clinical (c). The biopsy does not meet the criteria for pathologic staging.

   c. If the patient had surgery followed by other treatment(s) use code 3 or 9.

   d. If the size or extension of the tumor was greater after presurgical treatment than before treatment, use code 6. This code is likely to be used infrequently and maps to the "y" intercurrent treatment staging basis.

   e. If the patient had an autopsy, use code 2 if the diagnosis was known or suspected prior to death. Use code 8 if the malignancy was not known or suspected prior to death.

4. For sites/histologies where there is no TNM schema, this field must be coded 9, Not Applicable. These sites are also noted in the site specific schemas.

Note: *Although TNM staging is not collected by TCR, TNM is incorporated in the CS system; therefore rules must be consistent.*

These schemas are:

Other pharynx
Other digestive
Middle ear
Other sinus
Trachea
Other respiratory
Other adnexa
Other female genital
Other male genital
Other urinary
Brain and Other CNS
Other endocrine
Other eye
Melanoma of other Eye
Kaposi sarcoma
Hematopoietic, Reticuloendothelial, Immunoproliferative and Meyoloproliferative Neoplasms
Other Ill-defined and Unknown Primary Sites

5. Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography, lymphography, angiography, scintigraphy (nuclear scans), magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

6. The Eval fields should be codes based on how the information was obtained, even if the related fields (Tumor Size, CS Extension) are unknown. In other words, just because the tumor size is coded 999, the Eval field does not have to be coded 9.

CS Tumor Size/Ext Eval Standard Table

***Note**: Not all schemas use the Standard Table. Be sure to check the site-specific schemas before coding the field.*
***Note:** This table is also available in the Quick Reference, Standard Tables Section.*

Code	Description	Staging Basis
0	No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No surgical resection done. Evaluation based on endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, or other invasive techniques, including surgical observation without biopsy. No autopsy evidence used. ***Does not meet criteria for AJCC pathologic staging.***	c*
2	No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy)	p
3	Surgical resection performed WITHOUT pre-surgical systemic treatment or radiation **OR** surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed Evaluation based on evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination of the resected specimen ***Meets criteria for AJCC pathologic staging.***	p
5	Surgical resection performed WITH pre-surgical systemic treatment or radiation; tumor size/extension based on clinical evidence	c
6	Surgical resection performed WITH pre-surgical systemic treatment or radiation, BUT tumor size/extension based on pathologic evidence	y
8	Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy)	a
9	Unknown if surgical resection done Not assessed; cannot be assessed Unknown if assessed Not documented in patient record ***For sites with no TNM schema:*** not applicable	c

* For some primary sites, code 1 may be a pathologic staging bases, as determined by the site-specific chapter in the *AJCC Cancer Staging Manual, sixth edition.*

CS LYMPH NODES (NAACCR Item #2830) (CS MANUAL Version 01.04.00, pg I-33)

Description
Identifies the regional lymph nodes involved with cancer at the time of diagnosis.

CS Lymph Nodes General Guidelines

1. Code and document the specific regional lymph node chain farthest from the primary site that is involved by tumor either clinically or pathologically.

a. Document involved regional lymph nodes from the pathology report when the patient receives no radiation therapy or systemic treatment prior to surgery. Regional nodes are listed in each site/histology schema. Nodes farther away from the primary or in farther lymph node chains have higher codes with the exception of codes for Regional Nodes, NOS; Lymph Nodes, NOS; stated as N1 no other information; and so forth. Record the highest applicable code.

Example:
Peribronchial lymph nodes are positive on fine needle aspiration biopsy. Contralateral mediastinal mass noted on CT but not biopsied. Patient chooses radiation therapy as primary treatment. Code the contralateral mediastinal lymph node involvement as it is higher than the code for peribronchial lymph nodes.

b. Pathologic information takes precedence over clinical when there is a discrepancy on the same lymph node chain(s) if preoperative therapy was not administered.

Example:
Per physical exam axillary lymph nodes were “suspicious for involvement”. After axillary lymph node dissection, all 12 lymph nodes were negative. Document the number of lymph nodes examined and the negative findings (0/12 or, number of lymph nodes positive/number of lymph nodes examined).

c. For patient(s) with **primary of inaccessible sites** and early or localized disease receiving usual treatment, lymph nodes should be considered negative rather than unknown when there is no mention of regional lymph node involvement in the physical exam, pre-treatment diagnostic testing or surgical exploration.

d. Document the farthest involved regional lymph nodes based on information prior to surgery if the patient receives preoperative systemic therapy or radiation therapy.

Example:
Needle biopsy of the breast confirms ductal carcinoma. Patient has a hard matted mass in the axilla clinically suspicious for metastases. Patient receives 3 months of chemotherapy, then a modified radical mastectomy. The pathology report shows only scar tissue in the axillary lymph nodes. Code the CS Lymph nodes as 51 because the chemotherapy apparently “sterilized” the lymph nodes.

e. In the infrequent event that clinically involved regional lymph nodes do not respond to

neoadjuvant treatment and are, in fact, more extensively involved after preoperative treatment as determined by the operative or pathology report, code the farthest extension.

Example: Patient has needle biopsy-proven prostate cancer with no mention of involved lymph nodes on physical examination. He receives Lupron while deciding whether to undergo a radical prostatectomy. At the time of surgery, a laparoscopic pelvic lymph node biopsy is reported to show metastases. Code CS Lymph Nodes as 10 because the preoperative treatment (Lupron) had no effect on the lymph nodes.

f. Lymph nodes should be considered as not involved for primaries with in situ extension and coded as 00 (None). In situ by definition means non-invasive. If there is evidence of nodal involvement associated with a tumor described as in situ, it would indicate that an area of invasion was missed and the primary tumor is not an in situ lesion, so lymph nodes can be coded as appropriate for the case.

g. If there is direct extension of the primary tumor into a regional lymph node, record the involved lymph node in this field.

2. For solid tumors, the terms “fixed” or “matted” and “mass in the hilum, mediastinum, retroperitoneum, and/or mesentery” (with no specific information as to tissue involved) are considered involvement of lymph nodes.

a. Any other terms, such as “palpable”, “enlarged”, “visible swelling”, “shotty” or “lymphadenopathy” should be ignored unless there is a statement of involvement by the clinician.

EXCEPTION: *The terms* adenopathy, enlargement, *and* mass in the hilum or mediastinum *should be coded as involvement for lung primaries only.*

b. For lymphomas, any positive mention of lymph nodes indicates involvement of those lymph nodes.

c. Regional nodes are not palpable for inaccessible sites such (but not limited to) as **bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri, ovary, etc.** The best information on regional lymph node involvement will be on imaging studies or the surgeon’s description at the time of exploratory or definitive surgery. If regional lymph nodes for these sites are not mentioned in these reports, they are presumed to be clinically negative and should be coded to 00.

d. The terms “homolateral”, ipsilateral”, and “same side” are used interchangeably.

e. Any unidentified nodes included with the resected primary site specimen are to be coded as Regional Lymph Nodes, NOS. Coding of NOS categories for lymph nodes should be used only after an exhaustive search for more specific information.

f. Size of the involved regional nodes can be found on the pathology report and should be

documented if available.

g. For colon, rectosigmoid, and rectal primaries, if there is a statement about tumor nodule(s) in the pericolic or perirectal fat, use the following guidelines for coding regional lymph node involvement:
   1. Consider regional node involvement if the nodule has a smooth contour.
   2. Consider tumor extension if the nodule has an irregular contour.

h. Both positive and negative findings for lymph node involvement should be documented in the Staging Documentation text field.

CS Lymph Nodes Standard Table

Note: *The table is also available in the Quick Reference, Standard Table Section.*

Code	Description	TNM Mapping	SS 77 Mapping	SS 2000 Mapping
00	None; no regional lymph node involvement.	N0	None	None
	SITE/HISTOLOGY SPECIFIC SCHEMA CODES			
80	Lymph nodes, NOS.	NX	RN	RN
99	Unknown; regional lymph nodes cannot be assessed; not stated in medical record.	NX	U	U

For schemas that do not use CS Lymph nodes field

Code	Description
88	Not applicable

Note: *Documentation is* ***required*** *to support coding.*

Note: *Specific instructions for coding Regional Lymph Nodes for breast can be found in the site-specific coding guidelines in Appendix A, Breast, pg A-373*

Note: *Head and neck sites have different levels of lymph nodes according to sites. Refer to CS Manual pgs. I-35 throug I-38.*

REGIONAL LYMPH NODES POSITIVE (NAACCR ITEM #820) (FORDS pg. 103; SEER pg. 145 CS MANUAL pg. I-45)

Description
Describes the total number of regional lymph nodes examined by the pathologist and reported as containing malignant cells.

Explanation
This item is necessary for pathologic staging and helps determine treatment methods.

Coding Instructions

1. Record the total number of regional lymph nodes removed (as part of the first course of treatment) and examined, and reported as containing malignant cells by the pathologist. Involved distant lymph nodes should be coded in *CS Mets at DX (NAACCR Item #2850).*

2. The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

3. This field is to be recorded regardless of whether the patient received preoperative treatment.

4. This field is based on pathologic/histologic information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed but no lymph nodes were found, code as 98.

5. The number of regional lymph nodes positive **must be** equal to or less than the number nodes recorded in *Regional Lymph Nodes Examined* (NAACCR Item #830).

6. Code as 95 when the lymph nodes are not removed, but cytology or histology from a regional lymph node aspiration is positive for malignant cells.

7. Code to 99 for morphologies or sites where regional lymph node examination is not applicable:

   a. Placenta (C589)

   b. Brain and cerebral meninges (C700, C710–C719)

   c. Other parts of Central Nervous System (C701, C709, C720–C725, C728–C729)

   d. Hodgkin and non-Hodgkin lymphoma (M-959–972) **EXCEPT** 9700/3 and 9701/3

   e. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative neoplasms (M-9731–9734, 9740–9742, 9750–9758, 9760–9762, 9764–9769, 9800–9801, 9805, 9820, 9823, 9826–9827, 9831–9837, 9840, 9860–9861, 9863, 9866–9867, 9870–9876, 9891, 9895–9897, 9910, 9920, 9930–9931, 9940, 9945–9946, 9948, 9950, 9960–9964, 9970, 9975, 9980, 9982–9987, 9989)

   f. Unknown and ill-defined primary sites (C809,C420–C424, C760–C765, C767–C768, C770–C775, C778–C779; Note: For C42_ and C77_ other than hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin lymphomas as listed above, and Kaposi sarcoma 9140/3.

Note: *The field Lymph Nodes Positive is always coded 99 for* ***both*** *nodal and extranodal lymphomas.*

Regional Lymph Nodes Positive Standard Table

Note: The table may also be found in the Standard Tables, Quick Reference Section.

CODE	DESCRIPTION
00	All lymph nodes examined are negative.
01–89	1–89 regional lymph nodes are positive. (Code exact number of regional lymph nodes positive)
90	90 or more regional lymph nodes are positive.
95	Positive aspiration or core biopsy of lymph node(s) was performed.
97	Positive regional nodes are documented, but the number is unspecified.
98	No regional nodes were examined
99	Unknown whether regional lymph nodes are positive; not applicable; not stated in patient record.

REGIONAL LYMPH NODES EXAMINED (NAACCR Item #830) (FORDS pg. 102-102A; SEER pgs. 146, CS MANUAL Version 01.04.00 pg. I-46)

Description
Describes the total number of regional lymph nodes examined by the pathologist.

Explanation
This item is necessary for pathologic staging and helps determine treatment methods.

Coding Instructions

1. This field is based on pathologic information only. Record the total number of regional lymph nodes removed (as part of the first course of treatment) and examined by the pathologist.

2. The number of regional lymph nodes examined is cumulative from all procedures through the completion of surgeries in the first course of treatment.

3. Code only regional nodes in this field. Refer to the SEER Summary Staging Manual 2000 for site-specific identification of regional lymph nodes.

4. This field is to be recorded regardless of administered preoperative treatment.

***Note:** Removal of the primary tumor and a regional lymph node dissection may or may not be done in one surgical procedure.*

5. The number of regional lymph nodes examined must be equal to or greater than the number of nodes recorded in regional lymph nodes positive (NAACCR Item #820).

6. Code to 99 for morphologies or sites where regional lymph node examination is not applicable:

   a. Placenta (589)

b. Brain and cerebral meninges (C70.0, C71.0–C71.9)

c. Other parts of central nervous system (C701, C709, C720–C725, C728–C729)

d. Hodgkin and non-Hodgkin lymphoma (M-959–972) EXCEPT 9700/3 and 9701/3

e. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative neoplasms (M-9731–9734, 9740–9742, 9750–9758, 9760–9762, 9764–9769, 9800–9801, 9805, 9820, 9823, 9826–9827, 9831–9837, 9840, 9860–9861, 9863, 9866–9867, 9870–9876, 9891, 9895–9897, 9910, 9920, 9930–9931, 9940, 9945–9946, 9948, 9950, 9960–9964, 9970, 9975, 9980, 9982–9987, 9989)

f. Unknown and ill-defined primary sites (C809,C420–C424, C760–C765, C767–C768, C770–C775, C778–C779; Note: For C42_ and C77_ other than hematopoietic, reticuloendothelial, Immunoproliferative, or myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin lymphomas as listed above, and Kaposi sarcoma 9140/3.

Note: *The field Regional Lymph Nodes Examined is always coded 99 for both nodal and extranodal lymphomas.*

7. Do not code distant lymph nodes removed in this field.

Regional Lymph Nodes Examined Standard Table

Note: *The table may also be found in the Quick Reference, Standard Tables Section.*

Code	Description
00	No lymph nodes were examined.
01–89	1–89 lymph nodes were examined. (Code exact number of regional lymph nodes examined.)
90	90 or more lymph nodes were examined.
95	No regional lymph nodes were removed, but aspiration or core biopsy of regional lymph nodes was performed.
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated.
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated.
98	Regional lymph nodes were surgically removed, but the number of nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown.
99	It is unknown whether regional lymph nodes were examined; not applicable or negative; not stated in patient record.

Examples:

a. Pathology report states: Right lobectomy and lymph node dissection performed. Nine of twenty-two hilar nodes are positive for metastatic adenocarcinoma.

Code:
Regional nodes positive: 09
Regional nodes examined: 22

Document in text:
9/22 hilar nodes

b. Physical exam revealed a large lesion in the UOQ of the right breast. Incisional biopsy confirmed infiltrating ductal carcinoma. Patient refused work-up or treatment.

Code:
Regional nodes positive: 98
Regional nodes examined: 00

Document in text:
No nodes removed or examined

c. Pathology report states: Moderately differentiated mucinous adenocarcinoma of the cecum. Two of 10 right colic lymph nodes are positive for metastasis.

Code:
Regional nodes positive: 02
Regional nodes examined: 10

Document in text:
2/10 right colic nodes

d. Pathology report states: All regional nodes examined are negative.

Code:
Regional nodes positive: 00
Regional nodes examined: 98.

Document in text:
Regional nodes neg., # examined unknown

e. During work-up of a prostate carcinoma, CT of the pelvis revealed probable metastatic iliac lymph nodes.

Code:
Regional nodes positive: 98
Regional nodes examined: 00

Document in text:
Per CT probable metastatic iliac nodes

f. Patient was diagnosed with multiple myeloma.

Code:
Regional nodes positive: 99
Regional nodes examined: 99

Document in text:
Multiple myeloma

CS METS AT DX (NAACCR Item #2850) (CS MANUAL Version 01.04.00 pg I-47)

Description
Identifies the distant site(s) of metastatic involvement at time of diagnosis.

CS Mets at DX General Guidelines

1. Code and document the metastases present at diagnosis, whether the determination was clinical or pathological and whether or not the patient had any preoperative systemic therapy.

2. Assign the highest applicable code for metastases at diagnosis.

3. Disease progression should not be documented or coded.

4. Record CS Mets at Dx as Code 00 (None) rather than code 99 (Unknown) when the clinician proceeds with standard treatment of the primary site for clinically localized or early stage disease, since this action presumes that there are no distant metastases that would otherwise alter treatment. Code 99 can and should be used when there is reasonable doubt that the tumor is no longer localized and there is no documentation of distant metastases.

5. All metastatic disease and source of the information should be documented in the Staging Documentation text field.

CS Mets at DX Standard Table

Note: The table is also available in the Quick Reference, Standard Tables Section.

Code	Description	TNM	SS 77	SS 2000
00	No; None	M0	None	None
10	Distant lymph node(s)	M1	D	D
40	Distant metastases, except code 10; distant metastasis, NOS; carcinomatosis.	M1	D	D
	SITE/HISTOLOGY SPECIFIC SCHEMA CODES WHERE NEEDED			
50	(40) + (10)	M1	D	D
99	Unknown; distant metastasis cannot be assessed; not stated in medical record.	MX	U	U

For schemas that do no use the CS Mets at Dx field

Code	Description
88	Not applicable

Note: *Documentation is* ***required*** *to support coding.*

CS SITE-SPECIFIC FACTOR 1 (NAACCR Item #2880) (CS MANUAL Version 01.04.00 pg. I-51)

Note: *TCR collects this data field for pleura primaries only (C38.4). Facilities that collect this information for other sites refer to CS Manual pg I-51*

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Example:
Patient is diagnosed with mesothelioma of the pleura. CT of chest shows pleural effusion. Cytologic exam of pleural fluid is positive for malignant cells. Code the CS Site Specific Factor to 020, Pleural effusion, malignant.

Note: *Documentation is required to support coding. Collection of this data field is required in order to derive SSS.*

CS SITE SPECIFIC FACTOR 3 (NAACCR Item #2900) (CS MANUAL Version 01.04.00 pg I-55)

Note: *TCR collects this field for prostate primaries only (C61.9). Facilities that collect this information for other sites should refer to CS Manual pg. I-55.*

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Example:
Patient is diagnosed with adenocarcinoma of the prostate and decides to have a radical prostatectomy. The pathology report states tumor extends to seminal vesicles. Code CS Site Specific Factor 3 to 045, Extension to seminal vesicle(s).

Example:
Patient with adenocarcinoma of the prostate is treated with hormone therapy only. Code CS Site Specific Factor 3 to 097, No prostatectomy done within first course of treatment.

Note: *Documentation is required to support coding. Collection of this data field is required in order to derive SSS.*